

MEDICAL HISTORY FORM

- 1.) Complete ALL questions and fill in ALL blanks.
- 2.) Please fax completed form to 908-234-2070.

Name: _____

Today's Date: _____ Age: _____ Height: _____ Weight: _____

Dominant Hand: Right or Left Surgery to: Right or Left Shoulder
Right or Left Knee

REQUESTED TIME FRAME FOR SURGERY:

(please check one):

- _____ ASAP
_____ in the next several weeks
_____ in the next several months
_____ not sure
_____ other: _____ (please explain)

It is imperative that you discuss any travel plans with your surgical coordinator prior to scheduling surgery.

Please answer each of the following questions:

| | | |
|--|-----|----|
| Are you on any aspirin or blood thinners?..... | Yes | No |
| Do you have asthma?..... | Yes | No |
| Do you have a heart murmur/mitral valve prolapse?..... | Yes | No |
| Have you ever had a heart attack?..... | Yes | No |
| Do you have sleep apnea?..... | Yes | No |
| Have you ever been jaundiced/had hepatitis?..... | Yes | No |
| Do you have diabetes?..... | Yes | No |
| Do you have high blood pressure?..... | Yes | No |
| Do you have weakness/numbness in an arm/leg?..... | Yes | No |
| Could you be pregnant?..... | Yes | No |
| Do you have a pacemaker?..... | Yes | No |
| Do you smoke?..... | Yes | No |
| (If Yes, Amount per day: _____cigarettes or _____pack(s)) | | |
| Do you have any body piercings?..... | Yes | No |
| (If Yes, piercings must be removed for surgery) | | |
| Do you have any allergies to Latex and/or surgical tape?..... | Yes | No |
| If Yes please indicate reaction: _____ | | |
| Do you have any tattoos in close proximity to surgery site?..... | Yes | No |

